Plastic & Reconstructive Surgery

Tony L. Weaver, DO

Dear Patient,

We would like to take this opportunity to thank you for choosing HH Plastic & Reconstructive Surgery for your health care needs and to welcome you to our office. We are pleased that you have chosen us to provide you with medical services.

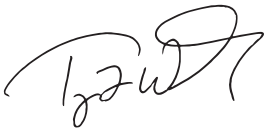
Our website *(hhplasticsurgery.org)* should help answer any questions you have about our office. We want you to know about our office services and what to expect at the time of your first visit.

Please complete the enclosed forms prior to your appointment. Please bring them with you on your appointment date, along with your identification cards, insurance cards and medication list, as well as your co-payments and/or deductibles.

If you are unable to keep this appointment or if you are going to be more than **15 minutes** late, please call our office at (256) 265-6851 as soon as possible. We will be happy to reschedule a more convenient time for you.

We look forward to seeing you and if you have any questions, please do not hesitate to call our office.

Sincerely,



Tony L. Weaver, MD
HH Plastic & Reconstructive Surgery

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Huntsville, AL 35801
o: (256) 265-6851
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SURGERY IN-TAKE FORM

Plastic & Reconstructive Surgery

Chart #: _____

HISTORY AND PHYSICAL

Name	Today's Date

Address

Home Phone	Business Phone	Cell Phone

Please check your preferred contact phone: ☐ Home ☐ Business ☐ Cell

SSN	Date of Birth

Email

Referred by (physician)	Primary Care Provider

Reason for visit

WHAT ARE YOUR MAIN CONCERNS OR QUESTIONS TODAY?

DESCRIPTION OF PRESENT ILLNESS

(include when your symptoms started)

CURRENT MEDICATIONS

Drug	Dose

Drug	Dose

MEDICATION ALLERGIES

Drug	Reaction

Latex allergy: ☐ Yes ☐ No

PAST MEDICAL HISTORY *Check all that apply*

- ☐ Headache
- ☐ Epilepsy/seizures
- ☐ Stroke
- ☐ Head injury/ concussion/whiplash
- ☐ Spinal cord injury
- ☐ Arthritis, type: _____
- ☐ Peripheral neuropathology
- ☐ Brain tumor
- ☐ Depression/anxiety
- ☐ Coronary artery disease/MI
- ☐ Irregular heartbeat/ atrial fibrillation
- ☐ Congestive heart failure
- ☐ Murmur
- ☐ High blood pressure
- ☐ Fibromyalgia
- ☐ Cancer, type: _____
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Alcohol use
  # of drinks/day: _____
  # of drinks/year: _____
- ☐ Smoking (current or past)
  # of packs/day: _____
  # of packs/year: _____
- ☐ COPD/Emphysema
- ☐ Pneumonia
- ☐ Asthma
- ☐ GERD/acid reflux
- ☐ Colon polyps
- ☐ Bleeding disorder
- ☐ Anemia
- ☐ Diabetes, type: _____
- ☐ Peripheral vascular disease
- ☐ Thyroid disease
- ☐ Menstrual/sexual dysfunction
- ☐ Other endocrine
- ☐ Live disease/hepatitis
- ☐ Kidney problems
- ☐ Bladder problems
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Allergy/hay fever
- ☐ Carotid artery disease
- ☐ Autoimmune disease (lupus, etc.)
- ☐ High cholesterol
- ☐ Sleep Apnea

☐ Other: _____

PAST SURGICAL HISTORY *Check all that apply*

- ☐ Amputation
- ☐ AV fistula creation
- ☐ AV graft
- ☐ Aortic valve replacemnt
- ☐ Appendectomy
- ☐ Legs bypassed:
  - ☐ Right
  - ☐ Left
- ☐ Back surgery
- ☐ Bronchoscopy (lung scope)
- ☐ CABG (Heart bypass)
- ☐ Carotid endarterectomy
- ☐ Carpal tunnel
  - ☐ Right
  - ☐ Left
- ☐ Cataract extratcion
- ☐ Gallbaldder removed
- ☐ Colon resection
- ☐ Craniotomy
- ☐ Gastric bypass
- ☐ Hemorrhoidectoy
- ☐ Hip replacement
  - ☐ Right
  - ☐ Left
- ☐ Invasive pain procedure
- ☐ Kidney transplant
- ☐ Knee arthroscopy
- ☐ Knee replacemnt
  - ☐ Right
  - ☐ Left
- ☐ Kyphoplasty
- ☐ Lumpectomey
- ☐ Mitral valve replaced
- ☐ Nephrectomy
- ☐ Pacemaker impanted
- ☐ Parathyroidectomy
- ☐ Pneumonectomy
- ☐ PTCA (angioplasty)
- ☐ Rotator cuff repair
  - ☐ Right
  - ☐ Left
- ☐ Abd. hysterectomy
- ☐ Hysterectomy/ovaries
- ☐ Ovaries removed
- ☐ Prostate surgery
- ☐ Shoulder surgery
  - ☐ Right
  - ☐ Left
- ☐ Sleep apnea surgery
- ☐ Thyroid surgery
- ☐ Tonsils removed
- ☐ Vascular surgery
- ☐ Breast augmentation
  - ☐ Right
  - ☐ Left
- ☐ Mastectomy
  - ☐ Right
  - ☐ Left
- ☐ Lumpectomy
  - ☐ Right
  - ☐ Left

☐ Other: _____

Advanced directives: ☐ Yes ☐ No
(Please provide a copy for records)

REVIEW OF SYSTEMS *Check all that apply*

ENT
- ☐ Earache
- ☐ Ear discharge
- ☐ Ringing of ears
- ☐ Decreased hearing
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Allergies
- ☐ Sinus trouble
- ☐ Goiter/thyroid
- ☐ Swollen glands

Respiratory
- ☐ Cough
- ☐ Dyspnea at rest
- ☐ Excessive sputum
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Shortness of breath at rest
- ☐ Emphysema/ bronchitis
- ☐ Pneumonia
- ☐ Hemopysis

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Memory loss
- ☐ Suicidal ideation
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Phobia
- ☐ Confusion

Cardiovascular
- ☐ Chest pains
- ☐ Palpitations
- ☐ Syncope
- ☐ Shortness of breath on exertion
- ☐ Orthopnea
- ☐ PND
- ☐ Peripheral edema
- ☐ Murmur
- ☐ Chest pain w/ exercise
- ☐ Swelling of ankles
- ☐ Lask EKG: _____

Endo
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive urination
- ☐ Unusual weight change
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Diabetes

Skin
- ☐ Rash
- ☐ Itching
- ☐ Dryness
- ☐ Suspicious lesions
- ☐ Hair/nail problems
- ☐ Lumps
- ☐ Masses

MS
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Stiffness
- ☐ Arthritis
- ☐ Sciatica
- ☐ Leg pain at night
- ☐ Leg pain with exertion
- ☐ Restless legs
- ☐ Numbness/ tingling
- ☐ Varicose veins
- ☐ Phlebitis

Eyes
- ☐ Blurring
- ☐ Double vision
- ☐ Irritation
- ☐ Discharge
- ☐ Vision loss
- ☐ Eye pain
- ☐ Sensitivity to light
- ☐ Cataracts
- ☐ Last eye exam: _____
- ☐ Glasses/contacts

Allergy
- ☐ Hives
- ☐ Allergic rash
- ☐ Hay fever
- ☐ Recurrent infections

GU
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Discharge
- ☐ Urinary tract infection
- ☐ Urinary Hesitancy
- ☐ Nighttime urination
- ☐ Incontinence
- ☐ Genital sores
- ☐ Decreased libido
- ☐ Erectile dysfunction
- ☐ Leakage of urine
- ☐ Kidney stones
- ☐ Frequent infections

HEME
- ☐ Bruise easily
- ☐ Difficulty stopping bleeds
- ☐ Enlarged lymph nodes
- ☐ Yellow jaundice
- ☐ Family history of bleeding
- ☐ Blood transfusion

Breast
- ☐ Lumps
- ☐ Nipple discharge
- ☐ Do self-exam

GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Jaundice
- ☐ Gas/bloating
- ☐ Indigestion/ heartburn
- ☐ Trouble swallowing
- ☐ Painful swallowing
- ☐ Ulcer
- ☐ Hemorrhoids
- ☐ Hepatitis

General
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Anorexia
- ☐ Fatigue
- ☐ Weakness
- ☐ Malaise
- ☐ Weight loss
- ☐ Sleep disorder

Neuro
- ☐ Headaches
- ☐ Dizziness

Allergies
- ☐ Seasonal allergies

PRIOR HOSPITALIZATIONS

(include reason)

FAMILY HISTORY

	Father	Mother	Father's parents	Mother's parents	Brother	Sister	Son	Daughter
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Sudden death	☐	☐	☐	☐	☐	☐	☐	☐
Rhuematic disease	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐

Cancer type: _____

	Father	Mother	Father's parents	Mother's parents	Brother	Sister	Son	Daughter
Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐
Neuromuscular	☐	☐	☐	☐	☐	☐	☐	☐
Headaches/ migraines	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune disease	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Neuromuscular	☐	☐	☐	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐	☐	☐	☐
AIDS	☐	☐	☐	☐	☐	☐	☐	☐

REMARKS

(include reason)

Completed by	Today's date

PATIENT INFORMATION

Plastic & Reconstructive Surgery

Name	Today's Date

Address

Home Phone	Business Phone	Cell Phone

Please check your preferred contact phone: ☐ Home ☐ Business ☐ Cell

SSN	Sex ☐ Female ☐ Male	Age	Date of Birth

Email

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer	Occupation

Employer Address

Referred by (physician)	Phone

Primary Care Provider	Phone

Result of on-the-job injury? ☐ Yes ☐ No	Result of accident? ☐ Yes ☐ No	Date of injury

SPOUSE/ACCOUNT GUARANTOR INFORMATION *Provide Account Guarantor information if patient is a minor*

Name	Date of Birth

SSN	Phone

Employer	Occupation

IN CASE OF EMERGENCY, CONTACT

Name	Relationship

Cell Phone	Alternate Phone (home/work)

INSURANCE INFORMATION *Provide Account Guarantor information if patient is a minor*

PRIMARY INSURANCE		
	Insurance Name	Relationship to Patient
	Subscriber's Name	Copay Amount
	Subscriber ID/Contract/Policy #	Group #
	Subscriber's SSN	Subscriber's Date of Birth
	Subscriber's Employer	Employer's Phone

SECONDARY INSURANCE		
	Insurance Name	Relationship to Patient
	Subscriber's Name	Copay Amount
	Subscriber ID/Contract/Policy #	Group #
	Subscriber's SSN	Subscriber's Date of Birth
	Subscriber's Employer	Employer's Phone

Person Responsible for this Account	Phone

When applicable, I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs or attorney's fees. I authorize HH Plastic & Reconstructive Surgery to release information to insurance carriers and for insurance carriers to release information to HH Plastic & Reconstructive Surgery concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignments applies.

Signature of Person Responsible	Today's Date	Time

Health System

101 SIVLEY ROAD • HUNTSVILLE, AL 35801 • 256-265-1000

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ SS Number (Optional)_____

Date of Birth _____ Address _____

Phone Number (_____)_____Date of Service_____ Patient Number

I authorize the use or disclosure of the above named individual's health information as described below:

1. Huntsville Hospital is authorized to make the disclosure.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ Facesheet	☐ Physician Orders	☐ Laboratory Results	Records Release Format
☐ Discharge Summary	☐ Outpatient Record	☐ Imaging Results	☐ e-delivery (Healthport Connect)
☐ History and Physical	☐ Emergency Dept. Record	☐ Bill / Claim Form	☐ CD
☐ Operative Note	☐ EKG Report	☐ Itemized Statement	☐ Paper
☐ Pathology Report	☐ EBC Application	☐ Other_____	
☐ Consultation Report	☐ Autopsy Report		
☐ Progress Notes			

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to, and used by, the following individual or organization:

   Name: _____

   Address: _____

5. For the purpose of _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

   _____

   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

or

I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
Treatment Enrollment in the health plan Eligibility for benefits

_____ _____ _____
SIGNATURE DATE TIME

_____ _____ _____ _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS DATE TIME

HUNTSVILLE HOSPITAL Medical District